MCBS MAIN STUDY - ROUND 34, FALL 2002

COMMUNITY COMPONENT

ST. CHARGE QUESTIONS (STATEMENT SERIES)

BOX ST1A	IF EXIT INTERVIEW AND PREVIOUS INTERVIEW NOT SKIPPED, GO TO NS. IF COMING FROM CTRL/E AND ONE OR MORE CHARGE BUNDLES PREVIOUSLY ENTERED, GO TO ST1a. IF MANAGED CARE PLAN (MEDICARE OR PRIVATE -- NOT MEDICAID) WAS IN EFFECT AT ANY TIME DURING THE CURRENT ROUND, GO TO ST1ahmo. OTHERWISE, GO TO ST1.

BOX ST1B OMITTED.

ST1ahmo. Now that we have finished talking about medical visits and prescribed medicines, let's talk about (your/SP's) medical costs. We should start by looking at any paperwork or written explanations of what was paid by Medicare or any insurance company.

[(Do you/Does SP) usually receive any statements or papers from Medicare or insurance, such as (MOST RECENT MEDICARE MANAGED CARE PLAN NAME), that show the charges for medical visits or equipment?/Last time, we recorded that (you/SP) (PREVIOUS ROUND RESPONSE TO ST1ahmo) received statements or papers from Medicare or insurance that show the charges for medical visits or equipment.] Please tell me if (currently) (you always receive/SP always receives) statements, sometimes receive(s) statements, or never receive(s) statements.

MHMOSTMT

ALWAYS	1	(ST1)
SOMETIMES	2	(ST1)
NEVER	3	(ST70)
REFUSED	-7	(ST1)
DON'T KNOW	-8	(ST1)

BOX ST1AA OMITTED IN ROUND 23.

ST1bhmo. OMITTED IN ROUND 23.

ST1chmo. OMITTED IN ROUND 23.

BOX ST1C OMITTED IN ROUND 23.

OMB # 0938-0568
Exp. 4/30/04

ST1. [Now that we have finished talking about medical visits and prescribed medicines, let's talk about (your/SP's) medical costs. We should start by looking at any paperwork or written explanations of what was paid by Medicare or any insurance company.]

Do you have any statements or paper from Medicare or insurance [that (you/SP) received since the last interview]?

MCSAVAIL

YES	1	(ST2)
NO	2	(ST70)
REFUSED	-7	(ST70)
DON'T KNOW	-8	(ST70)

ST1a. INTERVIEWER: YOU HAVE ENTERED THE FOLLOWING CLAIM CONTROL NUMBERS FOR THIS ROUND.

(MED/MSN): XXXXXX	(MED/MSN): XXXXXX	(MED/MSN): XXXXXX
INS: XXXXXX	INS: XXXXXX	INS: XXXXXX
ETC.		

[PRESS ENTER TO CONTINUE.]

Do you have any other statements or paper from Medicare or insurance?
[PROBE IF NECESSARY: Please include any Medicare or insurance statements that (you/SP) received since the last interview.]

MCSAVAIL

YES	1	(ST2)
NO	2	***BOX ST65***
REFUSED	-7	***BOX ST65***
DON'T KNOW	-8	***BOX ST65***

BOX ST1 OMITTED.

ST2. SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

MATCH UP MEDICARE AND INSURANCE STATEMENTS BY PROVIDER AND DATE OF SERVICE.
[PRESS ENTER TO LEAVE SCREEN.]

ST3. FOR THE (FIRST/NEXT) MEDICAL EVENT OR BUNDLE OF EVENTS TO BE ENTERED, WHAT TYPE OF STATEMENT(S) DO YOU HAVE?

STATTYPE

MEDICARE STATEMENT ONLY	1	(ST3a)
INSURANCE STATEMENT ONLY	2	(ST6a)
BOTH MEDICARE AND INSURANCE STATEMENTS	3	(ST3a)

ST3a. WHICH TYPE OF MEDICARE STATEMENT DO YOU HAVE TO ENTER?
[SEE SHOWCARD ST1 FOR MEDICARE STATEMENT EXAMPLES.]

MCARTYPE

"EXPLANATION OF YOUR MEDICARE PART B BENEFITS" (EXAMPLE 1)	1	(ST4)
"MEDICARE BENEFIT NOTICE" (EXAMPLE 2)	2	***BOX ST3A***
"YOUR RECORD OF PART B MEDICARE BENEFITS USED" (EXAMPLE 3)	3	(ST4)
MEDICARE SUMMARY NOTICE: PART B MEDICAL INSURANCE - ASSIGNED OR UNASSIGNED CLAIMS (EXAMPLE 4)	4	(ST4a)
MEDICARE SUMMARY NOTICE: PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS (EXAMPLE 5)	5	(ST4a)
MEDICARE SUMMARY NOTICE: PART A HOSPITAL INSURANCE - INPATIENT CLAIMS (EXAMPLE 6)	6	(ST4a)
MEDICARE SUMMARY NOTICE: PART A HOME HEALTH FACILITY CLAIMS (EXAMPLE 7)	7	(ST4a)
MEDICARE SUMMARY NOTICE: PART A HOSPICE FACILITY CLAIMS (EXAMPLE 8)	8	(ST4a)

ST4. ENTER UP TO FIVE MEDICARE CLAIM CONTROL NUMBERS FROM THE MEDICARE STATEMENT.
IF NO CLAIM CONTROL NUMBER(S) LISTED, ENTER SHIFT/8.
[USE CTRL/L TO LEAVE SCREEN.]
[DO NOT ENTER ANY CLAIM CONTROL NUMBERS THROUGH CTRL/K.]

MEDCLNUM	MEDICARE CLAIM CONTROL NUMBER: _____	***BOX ST2***
MEDCLNM2	MEDICARE CLAIM CONTROL NUMBER: _____	
MEDCLNM3	MEDICARE CLAIM CONTROL NUMBER: _____	
MEDCLNM4	MEDICARE CLAIM CONTROL NUMBER: _____	
MEDCLNM5	MEDICARE CLAIM CONTROL NUMBER: _____	
	DON'T KNOW -8	

ST4a. ENTER UP TO FIVE CLAIM CONTROL NUMBERS FROM THE MEDICARE SUMMARY NOTICE (MSN) ASSOCIATED WITH ONE CLAIM TOTAL.
IF NO CLAIM CONTROL NUMBER(S) LISTED, ENTER SHIFT/8.
[USE CTRL/L TO LEAVE SCREEN.]
[DO NOT ENTER ANY CLAIM CONTROL NUMBERS THROUGH CTRL/K.]

MSNCLNUM	MSN CLAIM CONTROL NUMBER: _____
MSNCLNM2	MSN CLAIM CONTROL NUMBER: _____
MSNCLNM3	MSN CLAIM CONTROL NUMBER: _____
MSNCLNM4	MSN CLAIM CONTROL NUMBER: _____
MSNCLNM5	MSN CLAIM CONTROL NUMBER: _____
	DON'T KNOW -8

BOX ST2	IF ST3=1 OR 3 AND ST3a=1 OR 3 AND FIRST NUMBER ENTERED AT ST4 DOES NOT = DK, GO TO ST5. IF FIRST NUMBER ENTERED AT ST4=DK, GO TO ***BOX ST3A***. IF ST3=1 OR 3 AND ST3a=4, 5, 6, 7, OR 8 AND FIRST NUMBER ENTERED AT ST4a DOES NOT = DK, GO TO ST5a. IF FIRST NUMBER ENTERED AT ST4a = DK, GO TO ***BOX ST3A***.

ST5. PLEASE ENTER THE FIRST CLAIM CONTROL NUMBER FROM THE MEDICARE STATEMENT AGAIN.

MEDICARE CLAIM CONTROL NUMBER: _____ ***BOX ST3***

MEDCLNUM
(TEMP VARIABLE)

ST5a. PLEASE ENTER THE FIRST CLAIM CONTROL NUMBER FROM THE MEDICARE SUMMARY NOTICE (MSN) AGAIN.

MSN CLAIM CONTROL NUMBER: _____

MSNCLNUM
(TEMP VARIABLE)

BOX ST3	EDIT CHECK FOR ST4/ST5 (MEDCLNUM): CHECK CLAIM NUMBER IN ST5 AGAINST FIRST MEDICARE CLAIM NUMBER IN ST4. IF SAME NUMBER AS FIRST NUMBER IN ST4, GO TO ***BOX ST3A***. IF NOT THE SAME NUMBER AS FIRST NUMBER IN ST4, GO TO ST6. EDIT CHECK FOR ST4a/ST5a (MSNCLNUM): CHECK CLAIM NUMBER IN ST5a AGAINST FIRST MSN CLAIM NUMBER IN ST4a. IF SAME NUMBER AS FIRST NUMBER IN ST4a, GO TO ***BOX ST3A***. IF NOT THE SAME NUMBER AS FIRST NUMBER IN ST4a, GO TO ST6aa.

ST6. YOU HAVE ENTERED THE MEDICARE CLAIM CONTROL NUMBERS DIFFERENTLY.

FIRST TIME: FIRST (MEDICARE CLAIM CONTROL NUMBER)

SECOND TIME: SECOND (MEDICARE CLAIM CONTROL NUMBER)

WHICH IS CORRECT?

WHICHNUM

FIRST	1	***BOX ST3A***
SECOND	2	***BOX ST3A***
NEITHER	3	(RE-ENTER) ***BOX ST3A***

ST6aa. YOU HAVE ENTERED THE CLAIM CONTROL NUMBERS FROM THE MEDICARE SUMMARY NOTICE (MSN) DIFFERENTLY.

FIRST TIME: FIRST (MSN CLAIM CONTROL NUMBER)

SECOND TIME: SECOND (MSN CLAIM CONTROL NUMBER)

WHICH IS CORRECT?

WHICHNUM

FIRST	1
SECOND	2
NEITHER	3

BOX ST3A	IF ST3 = 3, GO TO ST6a. OTHERWISE, GO TO ST8.

ST6a. ENTER THE CLAIM CONTROL NUMBER FROM THE INSURANCE STATEMENT. IF NO CLAIM CONTROL NUMBER LISTED, ENTER SHIFT/8.

INSCLNUM INSURANCE CLAIM CONTROL NUMBER: _____
DON'T KNOW ..... -8

BOX ST4 OMITTED IN ROUND 23.

ST7. OMITTED IN ROUND 23.

BOX ST4A OMITTED IN ROUND 23.

ST8. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

WHAT TYPE(S) OF EVENT(S) ARE INCLUDED IN THIS CHARGE BUNDLE ON THE [MEDICARE STATEMENT/ INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)]?
[CODE ALL THAT APPLY. PRESS CTRL/L TO LEAVE SCREEN.]

INCDATES	PROVIDER SERVICE DATES	1
INCOMS	OTHER MEDICAL EXPENSES	2
INCPMS	PRESCRIBED MEDICINES	3

BOX ST5	IF 1 CODED, GO TO ST9. IF 1 NOT CODED AND 2 CODED, GO TO ST17. IF 1 AND 2 NOT CODED AND 3 CODED, GO TO ST19.

ST9. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

WHICH MEDICAL PROVIDERS ARE IN THIS BUNDLE?
[ENTER ALL PROVIDERS.]
PROVNAME
COSTPROV

ST10. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX
PROVIDER: XXXXXXXXXXXXXXXXXXXXXXXXX

SELECT, CORRECT, ADD DATE(S) IN THIS CHARGE BUNDLE ON THE [MEDICARE STATEMENT/ INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)].

	TYPE	START DATE	STOP DATE	ROUND	
X	XXX	XX/XX/XX	XX/XX/XX	R(XX)	ORP

TYPE: 1=SEPARATELY BILLING LAB (SBL) 2=SEPARATELY BILLING DOCTOR (SBD) 3=DENTAL (DU) 4=HOSPITAL EMERGENCY ROOM (ER) 5=HOSPITAL INPATIENT STAY (IP) 6=HOSPITAL OUTPATIENT VISIT (OP) 7=INSTITUTIONAL STAY (IU) 8=HOME HEALTH PROFESSIONALS (HHP) 9=OTHER HOME HEALTH (AIDES, HOMEMAKERS, ETC.) (OHH) 10=ALL OTHER VISITS TO MEDICAL PROVIDERS (MP)

XCEVRNDC
RVLINKS
COSTBEGM **COSTENDM**
COSTBEGD **COSTENDD**
COSTBEGY **COSTENDY**

BOX ST5A	IF HH EVENT ADDED AND INTERVIEW IS TYPE 1, 4, 5, OR 9, GO TO ST10a. IF HH EVENT ADDED AND INTERVIEW IS TYPE 2 OR 7, EVENT GETS CURRENT ROUND DATE, GO TO ***BOX ST5B***. OTHERWISE, GO TO ***BOX ST5B***.

ST10a. WHICH REFERENCE PERIOD IS THE HOME HEALTH EVENT FOR?
HHROUND

Type 1
(REF. DATE FOR INT. 2 ROUNDS BACK FROM CURRENT ROUND - PREVIOUS INT. REF. DATE)
(2 ROUNDS BACK FROM CURRENT ROUND) 1
(PREVIOUS INT. REF. DATE - PREVIOUS INT. DATE) (PREVIOUS ROUND) 2
(PREVIOUS INT. DATE - TODAY) (CURRENT ROUND) 3

Type 4
(REF. DATE FOR INT. 2 ROUNDS BACK FROM CURRENT ROUND - PREVIOUS INT. REF. DATE)
[(2 ROUNDS BACK FROM CURRENT ROUND)/(PREVIOUS ROUND)] 1
[(2 ROUNDS BACK FROM CURRENT ROUND)/((PREVIOUS ROUND)] - TODAY)
(CURRENT ROUND) 3

Type 5
(REF. DATE FOR INT. 2 ROUNDS BACK FROM CURRENT ROUND - PREVIOUS INT. REF. DATE)
(2 ROUNDS BACK FROM CURRENT ROUND) 1
(PREVIOUS INT. REF. DATE - TODAY) (CURRENT ROUND) 3

BOX ST5B	IF MULTIPLE PROVIDERS ADDED AT ST9, GO TO ST10 AND COLLECT EVENT DATES FOR NEXT PROVIDER. OTHERWISE, GO TO ST11.

ST11. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX
PROVIDER: XXXX

ARE ALL THE PROVIDER EVENTS FROM THE CHARGE BUNDLE ON THE [MEDICARE STATEMENT/ INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)] SHOWN BELOW?

PROVIDER(S):

NAME	TYPE	DATE [TO DATE] (ORP)	(XX VISITS)
ETC.			
NAME	TYPE	DATE [TO DATE] (ORP)	(XX VISITS)
ETC.			

DATEMTCH

YES ..... 1 ***BOX ST6***
NO ..... 2 [DISPLAY MESSAGE]

BOX ST6	IF ONLY SELECTED OR CORRECTED DATES IN ST10, OR BILLING DATES ADDED FOR AN EXISTING HH EVENT, OR ADDED VISIT TYPES ALL = 1 OR 2 OR ALL ADDED DATES HAVE "ORP" FLAG AND ST8 CODED 2, GO TO ST17. IF ONLY SELECTED OR CORRECTED DATES IN ST10, OR BILLING DATES ADDED FOR AN EXISTING HH EVENT, OR ADDED VISIT TYPES ALL = 1 OR 2 OR ALL ADDED DATES HAVE "ORP" FLAG AND ST8 NOT CODED 2 AND CODED 3, GO TO ST19. IF ONLY SELECTED OR CORRECTED DATES IN ST10, OR BILLING DATES ADDED FOR AN EXISTING HH EVENT, OR ADDED VISIT TYPES ALL = 1 OR 2 OR ALL ADDED DATES HAVE "ORP" FLAG AND ST8 NOT CODED 2 OR 3, GO TO ***BOX ST49***. IF ANY ADDED UTILIZATION DATES IN ST10 DO NOT HAVE "ORP" FLAG, GO TO ST12, UNLESS UTILIZATION IS IU. IF UTILIZATION IS IU, GO TO ***BOX ST8***. SET FLAG TO NOTE THAT UTILIZATION WAS COLLECTED IN CHARGE SERIES.

ST12. Before we continue with this statement, I would like to ask you a few questions about the visit(s) I just added. [PRESS ENTER TO CONTINUE.]

BOX ST7	CHECK TYPE CODE AT ST10/CT72: IF 3, SET PROVIDER SPECIALTY AS "DENTIST" AND GO TO ***BOX ST8***. IF 4, 5, OR 6, GO TO ***BOX ST8***. IF 8 OR 9, GO TO ST12a. NOTE: THE DATES COLLECTED IN ST10 FOR HH UTILIZATION ARE THE DATES COVERED BY THE STATEMENT. IF 10 AND PROVIDER ADDED USING CTRL/A AT ST9/CT71, GO TO ST13. IF 10 AND DATE ONLY ADDED AT ST10/CT72, GO TO ***BOX ST8***.

ST12a. INTERVIEWER: IS (PROVIDER) THE NAME OF AN ORGANIZATION OR THE NAME OF A PERSON?
[NS9a]

FACPERS

ORGANIZATION 1
PERSON 2

BOX ST7A	IF ST12a = 1 AND TYPE AT ST10/CT72 = 8, GO TO HH6. IF ST12a = 1 AND TYPE AT ST10/CT72 = 9, GO TO HH25. IF ST12a = 2 AND TYPE AT ST10/CT72 = 8, GO TO HH3. IF ST12a = 2 AND TYPE AT ST10/CT72 = 9, GO TO HH20.

ST13. What kind of medical person is (PROVIDER)? ***BOX ST8***

PROVSPEC
PROVSPOS

BOX ST8	a.	SP HAS USED VA FACILITIES (HI36=1)	1	(b)
		SP HAS NOT USED VA FACILITIES (HI36=2 OR MISSING)	2	***BOX ST10***
	b.	VA FLAG SET FOR THIS PROVIDER	1	***BOX ST10***
		VA FLAG NOT SET FOR THIS PROVIDER	2	(ST14)

ST14. Is [(PROVIDER) associated with/(PROVIDER)] a Department of Veterans Affairs, or VA, facility?
[FACLVA]

VAPLACE

YES 1
NO 2
REFUSED ..... -7
DK ..... -8

BOX ST9 OMITTED.

BOX ST10	IF ST14 = 1, SET VA FLAG. THEN:			
	aa.	TYPE AT ST10/CT72 = 7	1	***BOX ST10A***
		TYPE AT ST10/CT72 ≠ 7	2	(a)
	a.	SP BELONGS TO A MANAGED CARE PLAN (HI10a, HI25, OR MEDICARE MANAGED CARE FLAG =1 FOR ANY PLAN)	1	(b)
		SP DOES NOT BELONG TO A MANAGED CARE PLAN (HI10a OR HI25=2 OR MISSING FOR ALL PLANS)	2	***BOX ST10A***
	b.	MANAGED CARE FLAG CODED YES FOR THIS PROVIDER	1	***BOX ST10A***
		MANAGED CARE FLAG CODED NO OR MISSING FOR THIS PROVIDER	2	(ST16)
		MANAGED CARE FLAG NOT SET FOR THIS PROVIDER	3	(ST15)

ST15. Is (PROVIDER) associated with (your/SP's) [READ MANAGED CARE PLAN NAME(S) BELOW] plan? [HMOPLAN]

HMOASSOC

YES	1	***BOX ST10A***
NO	2	(ST16)
REFUSED	-7	***BOX ST10A***
DK	-8	(ST16)

ST16. (Were you/Was SP) referred to (PROVIDER) by [READ MANAGED CARE PLAN NAME(S) BELOW]? [HMOREFD]

HMOREFER

YES	1
NO	2
REFUSED	-7
DK	-8

BOX ST10A	COLLECT NEW UTILIZATION FOR EACH VISIT DATE: IF TYPE AT ST10/CT72 = 3, AND ST16 = 2, GO TO DU5a. OTHERWISE GO TO DU7. IF TYPE AT ST10/CT72 = 4, AND ST16 = 2, GO TO ER3c. OTHERWISE, GO TO ER5. IF TYPE AT ST10/CT72 = 5, AND ST16 = 2, GO TO IP3c. OTHERWISE, GO TO IP7. IF TYPE AT ST10/CT72 = 6, AND ST16 = 2, GO TO OP3c. OTHERWISE, GO TO OP5. IF TYPE AT ST10=7, NOT COMING FROM INTERRUPT AND: IF ST8 CODED 2, GO TO ST17; IF ST8 NOT CODED 2 AND CODED 3, GO TO ST19; IF ST8 NOT CODED 2 OR 3, GO TO ***BOX ST49***. IF TYPE AT ST10/CT72 = 10, AND ST16 = 2, GO TO MP5a. OTHERWISE, GO TO ***BOX MP2A***. IF COMING FROM INTERRUPT, OPTION 7, GO TO ***BOX ST12***.

BOX ST11 OMITTED.

BOX ST12	STARTING AT ***BOX ST7***, COLLECT UTILIZATION FOR EACH ADDED VISIT DATE(S) INSIDE THE REFERENCE PERIOD (i.e., NO "ORP" FLAG AT ST10). THEN: IF ST8 CODED 2, GO TO ST17. IF ST8 NOT CODED 2 AND CODED 3, GO TO ST19. IF ST8 NOT CODED 2 OR 3, GO TO ***BOX ST49.*** IF COMING FROM INTERRUPT OPTION 7 PRIOR TO COMPLETING ST, GO TO INTERRUPT MENU. IF INTERRUPT USED AFTER NS, GO TO NS1. COLLECT CHARGE INFORMATION, RETURN TO INTERRUPT MENU.

ST17. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

SELECT, CORRECT OR ADD OTHER MEDICAL EXPENSES THAT ARE IN THIS CHARGE BUNDLE ON THE [MEDICARE STATEMENT/INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)].

	ITEM/TYPE	START DATE	STOP DATE	NUMBER OF PURCHASES	ROUND	
X R	XXXXXXXX	XX/XX/XX	XX/XX/XX	XX	R(xx)	ORP

ITEM: 1=GLASSES/CONTACTS 2=HEARING/SPEECH DEVICE 3=ORTHOPEDIC ITEM 4=DIABETIC SUPPLIES 5=AMBULANCE/RESCUE 6=PROSTHESIS 7=ALTERATIONS (HOME/CAR) 8=OXYGEN 9=KIDNEY DIALYSIS 10=ALL OTHER MEDICAL SUPPLIES

[IF ORTHOPEDIC ITEM: 21=BRACES/SUPPORTS 22=CANE 23=CORRECTIVE SHOES 24=CRUTCHES 25=WALKER 26=WHEELCHAIR/CART 27=STOCKINGS 91=OTHER (SPECIFY)]

[IF ALTERATION: 31=ELEVATOR 32=HANDRAILS (NOT TUB) 33=RAMPS 34=TUB HANDRAILS 35=TUB SEAT 36=ANY CAR ALTERATION 91=OTHER (SPECIFY)]

[IF OTHER MEDICAL SUPPLIES: 41=RAISED TOILET SEAT 42=PORTABLE TUB SEAT 43=SPECIAL CHAIR/CUSHION/MATTRESS 44=HOSPITAL BED 45=OSTOMY SUPPLIES 46=INCONTINENCE SUPPLIES 47=BANDAGES 48=PULMONARY EQUIPMENT 49=BLOOD PRESSURE EQUIPMENT 91=OTHER (SPECIFY)]

[IF OXYGEN ITEM: 51=OXYGEN/SUPPLIES 52=OXYGEN-RELATED EQUIPMENT]

[IF KIDNEY DIALYSIS ITEM: 61=KIDNEY DIALYSIS SUPPLIES 62=KIDNEY DIALYSIS EQUIPMENT]

XCEVRNDC
NUMLINKS

BOX ST12A	a) IF CTRL/A AND SP HAS ANY MEDICARE, MEDICAID, OR PRIVATE MANAGED CARE PLANS THIS ROUND AND: TYPE ADDED = 1, GO TO OM2a, THEN GO TO ST18. TYPE ADDED = 2, GO TO OM4a, THEN GO TO ST18. TYPE ADDED = 3 AND SUBCATEGORY = 21, 22, 23, OR 27, GO TO OM7aa, THEN GO TO ST18. TYPE ADDED = 4, GO TO OM10a, THEN GO TO ST18. TYPE ADDED = 5, GO TO OM12a, THEN GO TO ST18. TYPE ADDED = 6, GO TO OM14a, THEN GO TO ST18. TYPE ADDED = 8 AND SUBCATEGORY = 51, GO TO OM20aa, THEN GO TO ST18. TYPE ADDED = 9 AND SUBCATEGORY = 61, GO TO OM22aa, THEN GO TO ST18. b) IF CTRL/A AND TYPE ADDED = 24, 25, 26, 41-44, 48, 52, 62, OTHER SPECIFY ORTHOPEDIC ITEM, OR OTHER SPECIFY OTHER MEDICAL SUPPLIES, GO TO ST17aa. c) IF CTRL/A AND TYPE ADDED = 49, GO TO ***BOX ST12AC***. d) OTHERWISE, GO TO ST18.

ST17aa. Did (you/SP) buy or repair the (ITEM ADDED AT ST17), or did (you/SP) rent (it/them)?

RENTPROB

BUY/REPAIR	1	***BOX ST12AC***
RENT	2	***BOX ST12AA***
REFUSED	-7	***BOX ST12AC***
DK	-8	***BOX ST12AC***

BOX ST12AA	COMPARE RENTAL ITEM ADDED AT ST17 WITH EXISTING RENTAL ITEMS ON THE OME ROSTER. IF RENTAL TYPE MATCHES AND THE START DATE OF THE ITEM ADDED IS ON THE START DATE OR BETWEEN THE START DATE AND STOP DATE OF THE MATCHED ITEM, GO TO ST17bb. OTHERWISE, GO TO ***BOX ST12AB***.

ST17bb. ORIGINAL RENTAL EVENT(S)
ITEM/TYPE: (XXXXXXX) START DATE: (XX/XX/XX) STOP DATE: (XX/XX/XX)
ITEM/TYPE: (XXXXXXX) START DATE: (XX/XX/XX) STOP DATE: (XX/XX/XX)
ITEM/TYPE: (XXXXXXX) START DATE: (XX/XX/XX) STOP DATE: (XX/XX/XX)

ADDED RENTAL EVENT
ITEM/TYPE: (XXXXXXX) START DATE: (XX/XX/XX) STOP DATE: (XX/XX/XX)

THE RENTAL EVENT JUST ADDED OVERLAPS ONE OR MORE EXISTING RENTAL EVENTS OF THE SAME TYPE. (SEE INFORMATION ABOVE.)

ARE THE CHARGES SHOWN IN THE STATEMENT YOU HAVE NOW FOR ONE OF THE ORIGINAL RENTAL ITEMS, OR ARE THEY FOR A NEW RENTAL ITEM?

ORIGINAL RENTAL ITEM	1	ST17cc
NEW RENTAL ITEM	2	***BOX ST12AB***
DK	-8	***BOX ST12AB***

ST17cc. USE CTRL/B TO RETURN TO THE OME ROSTER. AT THE ROSTER, DELETE THE RENTAL ITEM THAT YOU JUST ADDED AND SELECT THE ORIGINAL RENTAL ITEM. [PRESS CTRL/B TO LEAVE THE SCREEN.]

BOX ST12AB	IF TYPE ADDED AT ST17 = 24, 25, 26 OR OTHER SPECIFY ORTHOPEDIC ITEM, GO TO OM7b. IF TYPE ADDED AT ST17 = 52, GO TO OM20b. IF TYPE ADDED AT ST17 = 62, GO TO OM22b. IF TYPE ADDED AT ST17 = 41-44, 48 OR OTHER SPECIFY OTHER MEDICAL SUPPLIES, GO TO OM26a1.

BOX ST12AC	IF COMING FROM ST17aa AND SP HAS ANY MEDICARE, MEDICAID, OR PRIVATE MANAGED CARE PLANS THIS ROUND, GO TO OM7aa AND THEN GO TO ***BOX ST12B***. OTHERWISE, GO TO ***BOX ST12B***.

BOX ST12B	IF ITEM OR ITEMS INCLUDED IN THIS BUNDLE RENTED (RENTPROB = 2), GO TO ST17a FOR EACH RENTAL ITEM. IF NO RENTAL ITEMS, GO TO ST18.

ST17a. (RENTAL ITEM) (RENTAL BEGIN DATE) - (LAST RENTAL DATE)

How many months are covered by this statement for the (RENTAL ITEM)?
[ENTER 96 IF LESS THAN 1 MONTH.]

MONTHCOV

MONTHS: .....
REFUSED ..... -7
DON'T KNOW ..... -8

BOX ST12C	GO TO ST17a FOR EACH RENTAL ITEM INCLUDED IN THIS BUNDLE. IF NO OTHER RENTAL ITEMS IN THIS BUNDLE, GO TO ST18.

ST18. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

ARE ALL OF THE OTHER MEDICAL EXPENSE ITEMS FROM THE CHARGE BUNDLE ON THE [MEDICARE STATEMENT/INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)] SHOWN BELOW?

OTHER MEDICAL EXPENSES:

ITEM	DATE TO [END DATE/RR/OW] (ORP) OR NUMBER OF PURCHASES
ETC.	

PROVIDER(S):

NAME	TYPE	DATE [TO DATE] (ORP)	(XX VISITS)
ETC.			

OMMTCH

YES ..... 1 ***BOX ST13***
NO ..... 2 [DISPLAY MESSAGE]

BOX ST13	IF ST8 CODED 3, GO TO ST19. IF ST8 NOT CODED 3, GO TO ***BOX ST49***. NOTE: FOR EACH OME ADDED AT ST17, SET FLAG TO NOTE THAT OME WAS COLLECTED IN CHARGE SERIES.

ST19. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

SELECT, CORRECT OR ADD PRESCRIPTION MEDICINES THAT ARE IN THIS CHARGE BUNDLE ON THE [MEDICARE STATEMENT/INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)].

	MEDICINE	NUMBER OF PURCHASES COVERED BY STATEMENT
X	XXXXXXXXXXX	XX

XCEVRNDC
NUMLINKS

ST20. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

ARE ALL OF THE PRESCRIBED MEDICINES FROM THE CHARGE BUNDLE ON THE [MEDICARE STATEMENT/INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)] SHOWN BELOW?

PRESCRIBED MEDICINES:

NAME	NUMBER OF PURCHASES
ETC.	

PROVIDER(S):

NAME	TYPE	DATE [TO DATE] (ORP)	(XX VISITS)
ETC.			

OTHER MEDICAL EXPENSES:

ITEM	DATE TO [END DATE/RR/OW] (ORP) OR NUMBER OF PURCHASES
ETC.	

PMMTCH

YES	1	***BOX ST13A***
NO	2	[DISPLAY MESSAGE]

BOX ST13A	
	IF MEDICINES ADDED AT ST19 AND SP HAS USED V.A. FACILITIES (HI36=1), GO TO ST20aa. IF MEDICINES ADDED AT ST19 AND SP HAS NOT USED V.A. (HI36=2 OR MISSING), GO TO ***BOX ST14***. IF NO MEDICINES ADDED AT ST19, GO TO ***BOX ST49.***

ST20aa. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

Did (you/SP) obtain (this purchase/any of these purchases) of (MEDICINE NAME) through the Department of Veterans Affairs or V.A.?

PMSATVA

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX ST14	
	IF MANAGED CARE PLAN (MEDICARE <u>OR</u> PRIVATE) WAS IN EFFECT AT ANY TIME DURING THE CURRENT ROUND, GO TO ST20a. IF <u>NO</u> MANAGED CARE PLAN WAS IN EFFECT DURING THE CURRENT ROUND, GO TO ST21.

ST20a. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

Did (you/SP) obtain (this purchase/any of these purchases) of (MEDICINE NAME) at [MANAGED CARE PLAN NAME(S) LISTED BELOW] or through a service or discount offered through [MANAGED CARE PLAN NAME(S) LISTED BELOW]?

[PROBE: This could include obtaining the purchases at a managed care plan pharmacy; at a pharmacy that honors (your/SP's) plan card; or through a mail order service that the managed care plan referred (you/SP) to.]

[DISPLAY ALL MANAGED CARE PLAN NAMES]

PMSATHMO

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

ST21. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
SURVEY REFERENCE PERIOD: XX/XX/XX TO XX/XX/XX

Before we continue with this statement, I would like to ask you a few questions about the prescribed medicine(s) I just added. [It would be very helpful for the following questions if we could look at the bottle(s) or container(s) for the medicine(s).]

[PRESS ENTER TO CONTINUE]

BOX ST15	GO TO ***BOX PM1B*** FOR EACH MEDICINE ADDED AT ST19. SET FLAG TO NOTE THAT MEDICINE WAS COLLECTED IN CHARGE SERIES.

BOX 16 OMITTED.

BOX ST17 OMITTED IN ROUND 23.

ST22. OMITTED IN ROUND 23.

ST23 THROUGH ST29 OMITTED.

BOX ST49	IF MEDICARE/INSURANCE "STATEMENT EXPECTED" FLAG SET DURING PREVIOUS ROUND FOR ANY EVENT IN THIS CHARGE BUNDLE, TURN FLAG OFF. IF ANY EVENT IN THIS BUNDLE ASSOCIATED WITH ANY OTHER BUNDLE FLAGGED FOR CPS, DO NOT BRING BUNDLE INTO CPS.

BOX ST50	CHECK ALL EVENTS ASSOCIATED WITH THIS CLAIM NUMBER: IF ALL EVENT DATES ARE BEFORE THE SURVEY REFERENCE PERIOD, GO TO ST50. IF ANY EVENT IS WITHIN THE SURVEY REFERENCE PERIOD OR AFTER THE SURVEY REFERENCE PERIOD FOR SPS WHO ARE DECEASED OR INSTITUTIONALIZED, GO TO ***BOX ST51***.

ST50. SINCE ALL EVENTS IN THIS BUNDLE ARE OUTSIDE THE SURVEY REFERENCE PERIOD, WE DO NOT NEED ANY CHARGE INFORMATION ABOUT THE BUNDLE.

GO TO ***BOX ST64C***

BOX ST51	IF ST3a = 1 OR 4 OR ST3 = 2, GO TO ST51. IF ST3a = 2, GO TO ST55. IF ST3a = 3, GO TO ST52c. IF ST3a = 5, 6, 7, OR 8, GO TO ST52b.

ST51. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
(PROVIDER: XXXX)

WAS ASSIGNMENT TAKEN FOR THIS CHARGE BUNDLE?

ASGNTAKE

YES	1
NO	2
CAN'T TELL	3

BOX ST51A OMITTED IN ROUND 22.

BOX ST52 OMITTED IN ROUND 23.

BOX ST52A	IF ST3a = 1 OR ST3 = 2, GO TO ST52. IF ST3a = 4, GO TO ST52a.

ST52. (MEDICARE/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
(PROVIDER: XXXX)

ENTER THE FOLLOWING AMOUNTS (FROM THE MEDICARE STATEMENT). IF AMOUNT NOT AVAILABLE, ENTER SHIFT/8.

TOTALCHG	A.	TOTAL CHARGE/BILLED AMOUNT:	$_____
MCAPPAMT	B.	TOTAL MEDICARE APPROVED AMOUNT:	$_____
MCPAYAMT	C.	TOTAL MEDICARE PAYMENT:	$_____
MCREDPCT	D.	MEDICARE PAYMENT REDUCTION:	_____%
STDATQNO			

BOX ST53	IF ST3=2, SKIP TO ***BOX ST54***. IF ST3=1 OR 3 AND LINE B=0, SKIP TO ST54. IF ST3=1 OR 3, ST51=1, AND ST52 LINE B OR LINE C IS MISSING, SKIP TO ST55. IF ST3=1 OR 3, ST51=2, AND ST52 LINE A OR LINE C IS MISSING, SKIP TO ST55. IF ST3=1 OR 3, ST51=3, AND ST52 LINE C OR BOTH LINES A AND B ARE MISSING, SKIP TO ST55. OTHERWISE, GO TO ST53.

ST52a. MSN CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)

ENTER THE FOLLOWING AMOUNTS FROM THE MSN:

TOTALCHG	B.	AMOUNT CHARGED:.....	$_____
MCAPPAMT	C.	MEDICARE APPROVED:.....	$_____
MCPAYAMT	D.	MEDICARE PAID (PROVIDER/YOU):.....	$_____
MAYBBILL	E.	YOU MAY BE BILLED:.....	$_____
STDATQNO			

[GO TO ***BOX ST53A***]

ST52b. MSN CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)

ENTER THE FOLLOWING AMOUNTS FROM THE MSN. [DISREGARD "AMOUNT CHARGED" IF IT APPEARS ON THE STATEMENT.]

DAYSUSED	A.	(BENEFIT DAYS USED:.....	_____DAYS)
TOTALCHG	B.	(AMOUNT CHARGED:.....	$_____)
NONCOVRD	C.	NON-COVERED CHARGES:.....	$_____
COINSUR	D.	(DEDUCTIBLE AND COINSURANCE/COINSURANCE):	$_____
MAYBBILL	E.	YOU MAY BE BILLED:.....	$_____
STDATQNO			

[GO TO ***BOX ST53A***]

ST52c. MEDICARE CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)

ENTER THE FOLLOWING AMOUNT FROM THE "RECORD OF PART B MEDICARE BENEFITS USED":

MAYBBILL	E.	LINE E, "YOUR TOTAL RESPONSIBILITY":.....	$_____
STDATQNO			

BOX ST53A	a. IF COMING FROM ST52a: IF ST51 = 1, THEN AMOUNT REMAINING = E IF ST51 = 2 AND EITHER B OR D = MISSING, THEN AMOUNT REMAINING = MISSING. IF ST51 = 2 AND BOTH B AND D NOT = MISSING, THEN AMOUNT REMAINING = B-D. GO TO c. b. IF COMING FROM ST52b OR ST52c: AMOUNT REMAINING = E c. IF AMOUNT REMAINING < $1.00 (INCLUDING NEGATIVE CALCULATED AMOUNTS), AND CASE IS NOT EXIT 40 SAMPLE, GO TO ***BOX ST64C***. IF EXIT 40 SAMPLE, GO TO NEXT SECTION. IF AMOUNT REMAINING = MISSING, GO TO ST61. IF AMOUNT REMAINING NOT = MISSING AND > $1.00, GO TO ST58.

ST53. MEDICARE CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)
TOTAL CHARGE = $(TOTAL CHARGE)

DO ANY INDIVIDUAL CHARGES ON THE MEDICARE STATEMENT HAVE AN APPROVED AMOUNT OF 0?

APPAMT0

YES	1	(ST54)
NO	2	***BOX ST54***
DON'T KNOW	-8	***BOX ST54***

ST54. MEDICARE CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)

ENTER TOTAL BILLED AMOUNT FOR CHARGES WITH APPROVED AMOUNT OF 0 ON APPROPRIATE LINE(S).

TOTALCHG	A. TOTAL CHARGE/BILLED AMOUNT:	$xxxxxxxx
MCAPPAMT	B. TOTAL MEDICARE APPROVED AMOUNT:	$xxxxxxxx
MCPAYAMT	C. TOTAL MEDICARE PAYMENT:	$xxxxxxxx
MCREDPCT	D. MEDICARE PAYMENT REDUCTION:	xxxxxxxx%
NOCOVAMT	E. NONCOVERED SERVICE (INCLUDING NO PART B AND TOO MANY SERVICES)	$_____
OTHERAMT **ARCALFLG**	F. ANY OTHER REASON (INCLUDING DUPLICATE CHARGE, "PROVIDER AGREED TO BILL" AND REQUEST TO RESUBMIT)	$_____

BOX ST54	a. SET FLAG TO NOTE THAT DATA WERE FROM ST52. b. IF ST54 SKIPPED, SET E=0 AND F=0. c. CALCULATE AMOUNT REMAINING AS FOLLOWS: IF ST51=1 AND IF B, C, D, AND F NOT MISSING, AMOUNT REMAINING = B - [C + (C*D)) + F IF ST51=1 AND B, C, D, OR F MISSING, THEN AMOUNT REMAINING = MISSING. IF ST51=2 AND IF A, C, D, AND F NOT MISSING, AMOUNT REMAINING = A - [(C+(C*D)) + F] IF ST51=2 AND A, C, D, OR F MISSING, THEN AMOUNT REMAINING = MISSING. IF ST51=3, USE THESE RULES IN PRIORITY ORDER: 1. IF A, C, AND F NOT MISSING, THEN AMOUNT REMAINING = A - (C + F) 2. IF B, C, D AND E NOT MISSING, THEN AMOUNT REMAINING = B - (C + (C*D)) + E 3. 3. IF B, C, AND E NOT MISSING, THEN AMOUNT REMAINING = B - (C + E) 4. IF NONE OF THESE CONDITIONS ARE TRUE, AMOUNT REMAINING=MISSING. d. IF AMOUNT REMAINING < $1.00 (INCLUDING NEGATIVE CALCULATED AMOUNTS), AND CASE IS NOT EXIT 40 SAMPLE, GO TO ***BOX ST64C***. IF EXIT 40 SAMPLE, GO TO NEXT SECTION. IF B NOT MISSING AND AMOUNT REMAINING < .02*B, AND CASE IS NOT EXIT 40 SAMPLE, GO TO ***BOX ST64C***. IF EXIT 40 SAMPLE, GO TO NEXT SECTION. OTHERWISE, SKIP TO ***BOX ST56***.

If charge bundle for inpatient stay or institutional stay and on Medicare statement, collection of $ data begins here.

ST55. MEDICARE CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)

HOW DOES THE MEDICARE STATEMENT SUMMARIZE THIS CLAIM?

MCSUMMRZ

MEDICARE PAID EVERYTHING	1	***BOX ST55***
BENEFICIARY (SP) RESPONSIBLE FOR SOME AMOUNT	2	(ST56)
SOME OTHER WAY	3	***BOX ST55***
DON'T KNOW	-8	***BOX ST55***

ST56. MEDICARE CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)

ENTER AMOUNT BENEFICIARY RESPONSIBLE FOR: $_____
(AMOUNT REMAINING AFTER MEDICARE PAID)
AREMAING
STDATQNO

BOX ST55	a. SET FLAG TO NOTE THAT AMOUNT WAS ENTERED IN ST56. b. IF ST55=3 OR DK, SET AMOUNT REMAINING TO MISSING. IF ST55 = 1, SET AMOUNT REMAINING TO 0. OTHERWISE, AMOUNT REMAINING = AMOUNT IN ST56. c. IF AMOUNT REMAINING < $1.00 BUT NOT MISSING, AND CASE IS NOT EXIT 40 SAMPLE, GO TO ***BOX ST64C***. IF EXIT 40 SAMPLE, GO TO NEXT SECTION. OTHERWISE, SKIP TO ***BOX ST56***.

BOX ST56	IF AMOUNT REMAINING IS MISSING, SKIP TO ST61. IF AMOUNT REMAINING NOT MISSING, SKIP TO ST58.

ST57 AND ***BOX ST57*** OMITTED.

ST58. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: (XXXXXX)
(PROVIDER: XXXX)

REVIEW CHARGE BUNDLE ON (MEDICARE) STATEMENT WITH RESPONDENT IF YOU HAVEN'T ALREADY DONE SO -- POINT OUT PROVIDER NAME, DATE(S), AND TYPE OF SERVICE. CODE "1" IF ALREADY KNOWN. OTHERWISE ASK:

So, I have an amount remaining of (AMOUNT REMAINING) that Medicare didn't pay. (Have you/Has SP) or any other source(, such as an insurance plan,) paid any of this amount?

ARWRONG	SP OR ANY SOURCE PAID	1	(ST62)
TCHGPAID	NOTHING HAS BEEN PAID	2	***BOX ST57A***
	AMOUNT REMAINING SEEMS WRONG	3	***BOX ST58***
	REFUSED	-7	***BOX ST57A***
	DON'T KNOW	-8	***BOX ST57A***

BOX ST57A	IF COMING FROM CPS AND EVENT COLLECTED IN PREVIOUS ROUND OR ST58=REF, GO TO ***BOX CPS11***/NEXT SECTION. IF COMING FROM CPS AND EVENT COLLECTED 2 ROUNDS PREVIOUS TO CURRENT ROUND OR THIS IS SP'S EXIT INTERVIEW (REGARDLESS OF WHEN EVENT COLLECTED), OR COMING FROM INTERRUPT, GO TO CPS3a. OTHERWISE, GO TO ***BOX ST64C*** IF NOT EXIT 40 SAMPLE. GO TO NEXT SECTION IF CASE IS EXIT 40 SAMPLE.

BOX ST58	a. SET FLAG THAT ST58 WAS CODED 3. SET ST58 TO -1. b. IF CURRENT AMOUNT REMAINING WAS ENTERED AT ST56 OR ST60 OR ST52c, SKIP TO ST60. IF CURRENT AMOUNT REMAINING WAS ENTERED AT ST52, GO TO ST59. IF CURRENT AMOUNT REMAINING WAS ENTERED AT ST52a, GO TO ST59a. IF CURRENT AMOUNT REMAINING WAS ENTERED AT ST52b, GO TO ST59b.

*ST59 and ST60 review and/or correct statement amounts: ST59 is used if the program calculated the amount remaining, ST60 if the interviewer entered the amount remaining from the statement. After interviewer corrects or confirms entries in ST59, program should recalculate amount remaining and return to **BOX ST56** and then ST58 (or ST61 if amount remaining now missing).*

ST59. THESE AMOUNTS WERE ENTERED FROM THE (MEDICARE/INSURANCE) STATEMENT: [MAKE CORRECTIONS AS NECESSARY.]

TOTALCHG	A. TOTAL CHARGE/BILLED AMOUNT:	$xxxxxxxx	$_____
MCAPPAMT	B. TOTAL MEDICARE APPROVED AMOUNT:	$xxxxxxxx	$_____
MCPAYAMT	C. TOTAL MEDICARE PAYMENT:	$xxxxxxxx	$_____
MCREDPCT	D. MEDICARE PAYMENT REDUCTION:	xxxxxxxx%	$_____
NOCOVAMT	E. NONCOVERED SERVICE (INCLUDING NO PART B AND TOO MANY SERVICES)	$xxxxxxxx	$_____
OTHERAMT	F. OTHER REASON (INCLUDING DUPLICATE CHARGE, "PROVIDER AGREED TO BILL" AND REQUEST TO RESUBMIT)	$xxxxxxxx	$_____
AREMAING			
ARCALFLG	G. AMOUNT REMAINING AFTER MEDICARE PAYMENT	$XXXXXXX	

CHANGAMT DO YOU WANT TO MAKE ANY CHANGES?

YES ..... .1(RE-ENTER A-F) ***BOX ST59***
NO ..... .2 ***BOX ST59***

BOX ST59	a. IF ANY CHANGES MADE IN ST59, RECALCULATE AMOUNT REMAINING, USING RULES IN ***BOX ST54***. b. IF AMOUNT REMAINING NOT MISSING AND < $1.00, GO TO ***BOX ST64C*** IF CASE IS NOT EXIT 40 SAMPLE. IF CASE IS EXIT 40 SAMPLE, GO TO NEXT SECTION. OTHERWISE, RETURN TO ***BOX ST56***.

ST59a. THESE AMOUNTS WERE ENTERED FROM THE MSN:
[MAKE CORRECTIONS AS NECESSARY.]

TOTALCHG	B. AMOUNT CHARGED:	$xxxx.xx	$_____
MCAPPAMT	C. MEDICARE APPROVED:	$xxxx.xx	$_____
MCPAYAMT	D. MEDICARE PAID (PROVIDER/YOU):	$xxxx.xx	$_____
MAYBBILL	E. YOU MAY BE BILLED:	$xxxx.xx	$_____

CHANGAMT DO YOU WANT TO MAKE ANY CHANGES?

YES ..... 1 (RE-ENTER B-E) ***BOX ST59A***
NO ..... 2 ***BOX ST59A***

ST59b. THESE AMOUNTS WERE ENTERED FROM THE MSN:
[MAKE CORRECTIONS AS NECESSARY.]

DAYSUSED	(A. BENEFIT DAYS USED:	xxx	_____DAYS)
TOTALCHG	(B. AMOUNT CHARGED:	$xxxx.xx	$_____)
NONCOVRD	C. NON-COVERED CHARGES:	$xxxx.xx	$_____
COINSUR	D. (DEDUCTIBLE AND COINSURANCE/COINSURANCE)	$xxxx.xx	$_____
MAYBBILL	E. YOU MAY BE BILLED:	$xxxx.xx	$_____

CHANGAMT DO YOU WANT TO MAKE ANY CHANGES?

YES ..... 1 (RE-ENTER A-E) ***BOX ST59A***
NO ..... 2 ***BOX ST59A***

BOX ST59A	a. IF ANY CHANGES MADE IN ST59a OR ST59b, REDETERMINE AMOUNT REMAINING USING RULES IN ***BOX ST53A***. b. IF AMOUNT REMAINING NOT MISSING AND < $1.00, GO TO ***BOX ST64C*** IF CASE IS <u>NOT</u> EXIT 40 SAMPLE. IF CASE IS EXIT 40 SAMPLE, GO TO NEXT SECTION. IF AMOUNT REMAINING = MISSING, GO TO ST61. IF AMOUNT REMAINING NOT = MISSING AND > $1.00, GO TO ST58.

ST60. MEDICARE CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)

THE AMOUNT BELOW WAS PREVIOUSLY ENTERED FROM A MEDICARE STATEMENT AS THE AMOUNT THE BENEFICIARY WAS RESPONSIBLE FOR (THE AMOUNT REMAINING).

G. AMOUNT REMAINING ..... $XXXXXXX $_____

DO YOU WANT TO CHANGE THIS AMOUNT?

CHANGEAR	YES	1	(RE-ENTER G); ***BOX ST60***
STDATQNO	NO	2	***BOX ST60***

BOX ST60	a. IF ANY CHANGES MADE IN ST60, SET AMOUNT REMAINING TO AMOUNT ENTERED IN ST60. b. IF AMOUNT REMAINING NOT MISSING AND < $1.00, GO TO ***BOX ST64C***, IF CASE IS NOT EXIT 40 SAMPLE. IF CASE IS EXIT 40 SAMPLE, GO TO NEXT SECTION. OTHERWISE, RETURN TO ***BOX ST56***.

ST61 is for charge bundles with missing amount remaining.

ST61. (MEDICARE/MSN/INSURANCE) CLAIM CONTROL NUMBER: XXXXXX
(PROVIDER: XXXX)
TOTAL CHARGE = $(TOTAL CHARGE)

REVIEW CHARGE BUNDLE ON STATEMENT WITH RESPONDENT IF YOU HAVEN'T ALREADY DONE SO -- POINT OUT PROVIDER NAME, DATE(S), AND TYPE OF SERVICE.

(Besides Medicare,) (have you/has SP) or any other source(, such as an insurance plan,) paid anything for this?

TCHGPAID

SP OR ANY SOURCE PAID	1	(ST62)
NOTHING HAS BEEN PAID	2	***BOX ST60A***
REFUSED	-7	***BOX ST60A***
DON'T KNOW	-8	***BOX ST60A***

BOX ST60A	IF COMING FROM CPS AND EVENT COLLECTED IN PREVIOUS ROUND OR ST61=REF, GO TO ***BOX CPS11***/NEXT SECTION. IF COMING FROM CPS AND EVENT COLLECTED 2 ROUNDS PREVIOUS TO CURRENT ROUND, OR THIS IS SP'S EXIT INTERVIEW (REGARDLESS OF WHEN EVENT COLLECTED), OR COMING FROM INTERRUPT, GO TO CPS3a. OTHERWISE, GO TO ***BOX ST64C*** IF CASE IS NOT EXIT 40 SAMPLE. IF CASE IS EXIT 40 SAMPLE, GO TO NEXT SECTION.

ST62. (REFER TO INSURANCE STATEMENT.)
TOTAL CHARGE = $(TOTAL CHARGE)

Who (else) paid (besides Medicare)? How much did (SOURCE) pay?

ENTER ALL PAYMENT AMOUNTS; USE ARROW KEYS; CTRL/A TO ADD A SOURCE; ARROW TO THE SELECT COLUMN AND ENTER "X" TO CORRECT SOURCE NAME OR ADD AMOUNT; ESC TO LEAVE SCREEN.

OSOPTEXT **PAYMDMEM**
PAYMTYPE **PAYMPLAN**
PAYMAMT **PAYMOSOP**

AMOUNT REMAINING $xxxxxxxxxxx

__ SP/FAMILY	$_____
__ PROVIDER DISCOUNT/COURTESY	$_____
__ [VA (DEPT. OF VETERANS AFFAIRS)]	$_____
__ SOP 1	$_____
__ SOP 2	$_____
__ SOP 3	$_____
__ (NAME OF DM)	$_____

BOX ST61	SOP ADDED IN ST62/ST66	1	(ST63)
	NO SOP ADDED IN ST62/ST66	2	***BOX ST63***

ST63. [What type of health insurance plan is (SOP NAME)?]

PAYMISHI
PLSOPFLG

MEDICAID/MEDICAID MANAGED CARE PLAN	1	***BOX ST62***
OTHER PUBLIC PLAN (OTHER THAN MEDICAID)	2	***BOX ST62***
PRIVATE HEALTH INSURANCE	3	***BOX ST62***
NOT A HEALTH INSURANCE PLAN (INCLUDING VA)	4	***BOX ST62(c)***
MILITARY PLAN OTHER THAN VA	5	***BOX ST62(c)***
NOT SP'S INSURANCE PLAN (PLAN BELONGS TO SOMEONE ELSE)	6	***BOX ST62(c)***
MEDICARE MANAGED CARE PLAN	7	***BOX ST62A***
DISCOUNT/SAVINGS MEMBERSHIP	8	***BOX ST62(d)***
REFUSED	-7	***BOX ST62(c)***
DON'T KNOW	-8	***BOX ST62(c)***

BOX ST62	a. IF ST63=1 AND MEDICAID PREVIOUSLY ENTERED, DISPLAY MESSAGE, "MEDICAID ALREADY ON PLAN ROSTER. RESELECT OR USE CTRL/B." OTHERWISE, ASK HI6-HI10d, THEN GO TO (b). IF ST63=2, ASK HI13-HI16a, THEN GO TO (b). IF ST63=3, ASK HI21-HI33c, THEN GO TO (b). b. ADD SOP TO PLAN ROSTER. SET FLAG THAT PLAN WAS COLLECTED IN SOP ROSTER. c. IF ANOTHER SOP ADDED IN ST62/ST66, RETURN TO ST63. IF NO OTHER SOP ADDED IN ST62/ST66, GO TO ***BOX ST63***. d. SET FLAG THAT DM WAS COLLECTED IN SOP ROSTER. THEN GO TO ***BOX DM2***.

BOX ST62A	IF MEDICARE MANAGED CARE PLAN ADDED AND NO OTHER MEDICARE MANAGED CARE PLAN IS CURRENT, GO TO HIMC3. OTHERWISE, GO TO HIMC4.

BOX ST63	a. IF AMOUNT REMAINING IS MISSING OR ALL PAYMENT AMOUNTS IN ST62 ARE DK OR REF OR COMING FROM ST66, SKIP TO ***BOX ST64***. b. IF AMOUNT REMAINING NOT MISSING BUT ANY ST62 AMOUNT = REF OR DK AND IF THE TOTAL OF ALL NON-MISSING ST62 AMOUNTS = OR GREATER THAN THE AMOUNT REMAINING, GO TO ST65a. c. ADD ALL PAYMENTS FROM ST62. COMPARE TOTAL AMOUNT REMAINING: IF TOTAL PAYMENTS IN ST62 = AMOUNT REMAINING, SKIP TO ***BOX ST64.*** IF THE DIFFERENCE BETWEEN TOTAL PAYMENTS AND AMOUNT REMAINING IS > $1.00 AND TOTAL PAYMENTS IS < AMOUNT REMAINING, GO TO ST64. IF THE DIFFERENCE BETWEEN TOTAL PAYMENTS AND AMOUNT REMAINING IS > $1.00 AND TOTAL PAYMENTS IS > AMOUNT REMAINING, GO TO ST65. OTHERWISE, GO TO ***BOX ST64B.***

ST64. TOTAL CHARGE = $(TOTAL CHARGE)

AMOUNT REMAINING (AFTER MEDICARE PAYMENT)	$XXXXXXXXXXX
SP/FAMILY	$XXXXXXXXXXX
SOP 1	$XXXXXXXXXXX
TOTAL OF NON-MEDICARE PAYMENTS	$XXXXXXXXXXX
AMOUNT UNPAID	$XXXXXXXXXXX

There seems to be some amount still unpaid. [REVIEW WITH RESPONDENT.] Is that correct?

AMTSCORR

ENTRIES ABOVE ARE CORRECT	1	***BOX ST64***
SOP NEEDS ADDITION OR CORRECTION	2	(ST66)
AMOUNT REMAINING SEEMS INCORRECT	3	(ST64a)
REFUSED	-7	***BOX ST64***
DON'T KNOW	-8	***BOX ST64***

ST65. TOTAL CHARGE = $(TOTAL CHARGE)

AMOUNT REMAINING (AFTER MEDICARE PAYMENT)	$XXXXXXXXXXX
SP/FAMILY	$XXXXXXXXXXX
SOP 1	$XXXXXXXXXXX
TOTAL OF NON-MEDICARE PAYMENTS	$XXXXXXXXXXX
AMOUNT OVERPAID	$XXXXXXXXXXX

There seem to be more payments than the amount left after Medicare paid. [REVIEW WITH RESPONDENT.] Is that correct?

AMTSCORR

ENTRIES ABOVE ARE CORRECT	1	***BOX ST64***
SOP NEEDS ADDITION OR CORRECTION	2	(ST66)
AMOUNT REMAINING SEEMS INCORRECT	3	(ST64a)
REFUSED	-7	***BOX ST64***
DON'T KNOW	-8	***BOX ST64***

ST65a. TOTAL CHARGE = $(TOTAL CHARGE)

AMOUNT REMAINING (AFTER MEDICARE PAYMENT)	$XXXXXXXXXXX
SP/FAMILY	$XXXXXXXXXXX
SOP 1	$XXXXXXXXXXX

INTERVIEWER: THE AMOUNTS ENTERED FOR THE SOURCES OF PAYMENT EQUAL OR EXCEED THE (TOTAL CHARGE/AMOUNT REMAINING), WITH AT LEAST ONE SOP BEING A MISSING AMOUNT. VERIFY ALL AMOUNTS AS ENTERED.

AMTSCORR

ENTRIES ABOVE ARE CORRECT	1	***BOX ST64***
SOP NEEDS ADDITION OR CORRECTION	2	(ST66)
AMOUNT REMAINING SEEMS INCORRECT	3	(ST64a)
REFUSED	-7	***BOX ST64***
DON'T KNOW	-8	***BOX ST64***

ST64a. TOTAL CHARGE = $(TOTAL CHARGE)

(ST64OV, ST65OV)

AMOUNT REMAINING (AFTER MEDICARE PAYMENT)	$XXXXXXXXXXX
SP/FAMILY	$XXXXXXXXXXX
SOP 1	$XXXXXXXXXXX
(TOTAL OF NON-MEDICARE PAYMENTS	$XXXXXXXXXXX)
[AMOUNT (UNPAID/OVERPAID)	$XXXXXXXXXXX]

INTERVIEWER: USE CTRL/K TO EXPLAIN WHY THE AMOUNT REMAINING SEEMS INCORRECT.

BOX ST63A	GO TO ***BOX ST64***.

ST66. TOTAL CHARGE = $(TOTAL CHARGE)

(THE FOLLOWING PAYMENT INFORMATION WAS ENTERED PREVIOUSLY.) CORRECT PAYMENT AMOUNTS, ADD SOURCES AS NECESSARY.

USE ARROW KEYS; CTRL/A TO ADD A SOURCE; ARROW TO THE SELECT COLUMN AND ENTER "X" TO CORRECT SOURCE NAME OR ADD AMOUNT; TO ERASE AN "X," PRESS SPACE BAR. ESC TO LEAVE SCREEN.

AMOUNT REMAINING $xxxxxxxxxxx

__ SP/FAMILY	$XXXXXXX
__ PROVIDER DISCOUNT/COURTESY	$_____
(__ MEDICARE	$_____)
__ [VA (DEPT. OF VETERANS AFFAIRS)]	$_____
__ SOP 1	$XXXXXXX
__ SOP 2	$_____
__ SOP 3	$_____
__ (NAME OF DM)	$_____

OSOPTEXT

BOX ST64A	IF SOP IS ADDED AT ST66, GO TO ST63 FOR THAT SOP.

BOX ST64	SP/FAMILY PAYMENT GREATER THAN $5.00	1	(ST67)
	SP/FAMILY PAYMENT LESS THAN OR EQUAL TO $5.00	2	***BOX ST64B***

ST67. I have recorded that (you have/SP has) paid (SP/FAMILY PAYMENT AMOUNT IN ST62 OR ST66). Do you expect any source to pay (you/SP) back any or all of that amount?

EXPPAYBK

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX ST64B	IF COMING FROM CPS AND: : ST67 = 1 AND EVENT COLLECTED IN PREVIOUS ROUND, GO TO ***BOX CPS11***. : ST67 = 1 AND EVENT COLLECTED 2 ROUNDS PREVIOUS TO CURRENT ROUND OR THIS IS SP'S EXIT INTERVIEW (REGARDLESS OF WHEN EVENT COLLECTED) OR COMING FROM INTERRUPT, GO TO CPS3b. : ST67 = 2, -1, REF OR DK AND EVENT COLLECTED IN PREVIOUS ROUND OR COLLECTED 2 ROUNDS PREVIOUS TO CURRENT ROUND, GO TO ***BOX CPS11***. OTHERWISE, GO TO ***BOX ST64C*** IF CASE IS NOT EXIT 40 SAMPLE. IF CASE IS EXIT 40 SAMPLE, GO TO NEXT SECTION.

ST68. OMITTED.

BOX ST64C	IF ST3a = 1, OR 4-8, GO TO ST68a. IF ST3a = 2 OR 3, GO TO ST68b. IF ST3 = 2, GO TO ST68a.

ST68a. IS THERE ANOTHER CHARGE BUNDLE TO ENTER FROM THIS [MEDICARE STATEMENT/INSURANCE STATEMENT/MEDICARE SUMMARY NOTICE (MSN)]?

YES 1 (ST3)
NO 2 (ST68b)

ST68b. IS THERE ANOTHER MEDICARE, MSN, OR INSURANCE STATEMENT TO ENTER?

YES 1 (ST3)
NO ..... 2 ***BOX ST65***

BOX ST65	1) IF ALL CURRENT ROUND EVENTS ARE LINKED TO CHARGES OR IF ALL EVENTS NOT YET LINKED TO CHARGES ARE: PMEDS WHERE PM6A=0, REF, OR DK; OR OMES WHERE OM25 = REF OR DK; OR EVENT IS IU; OR EVENT IS IP AND IP5 = 95; OR EVENT IS HH WHERE ONLY SERVICE PROVIDED IS MEAL DELIVERY; OR EVENT IS OME ALTERATION WHERE OM30 = 95; THEN GO TO ST69. 2) OTHERWISE, GO TO ST70.

ST69. YOU HAVE COMPLETED ENTERING CURRENT ROUND CHARGE INFORMATION FOR THIS CASE.

[PRESS ENTER TO CONTINUE.]

ST70. THIS IS THE LAST SCREEN IN THE SECTION WHERE YOU CAN BACKUP.
[NOBACKUP]

IF YOU WANT TO CORRECT ANYTHING, PRESS CTRL/B.

OTHERWISE, PRESS ENTER TO CONTINUE.

BOX ST66	1) IF ALL CURRENT ROUND EVENTS ARE LINKED TO CHARGES OR IF ALL EVENTS NOT YET LINKED TO CHARGES ARE: PMEDS WHERE PM6A=0, REF, OR DK; OR OMES WHERE OM25 = REF OR DK; OR EVENT IS IU; OR EVENT IS IP AND IP5 = 95; OR EVENT IS HH WHERE ONLY SERVICE PROVIDED IS MEAL DELIVERY; OR EVENT IS OME ALTERATION WHERE OM30 = 95; THEN GO TO ***BOX CPS1***. 2) OTHERWISE, GO TO ***BOX NS1*** FOR CURRENT ROUND EVENTS NOT LINKED TO CHARGES.

ATTACHMENT ST1

MEDICAL PROVIDER TYPE LIST

1	DENTIST/DENTAL PROVIDER
2	MEDICAL DOCTOR
29	ACUPUNCTURIST
3	AUDIOLOGIST
4	CHIROPRACTOR
5	CLINICAL SOCIAL WORKER
6	DIETITIAN-NUTRITIONIST
7	HEARING THERAPIST
8	HOME HEALTH/HEALTH AIDE
9	HOMEMAKER
30	HOMEOPATH
10	HOSPICE WORKER
11	I.V. THERAPIST
28	LICENSED PRACTICAL NURSE (LPN)
31	MASSAGE THERAPIST
32	NATUROPATH
12	NURSE (RN)
13	NURSE PRACTITIONER
14	NURSE'S AIDE
15	OCCUPATIONAL THERAPIST (OT)
16	OPTOMETRIST (OD)
17	OSTEOPATH (DO)
18	PARAMEDIC
19	PHYSICAL THERAPIST (PT)
20	PHYSICIAN'S ASSISTANT
21	PODIATRIST (FOOT DOCTOR)
22	PSYCHOLOGIST
23	RESPIRATORY THERAPIST
24	SOCIAL/CASE WORKER
25	SPEECH THERAPIST
26	THERAPIST (MENTAL HEALTH)
27	X-RAY TECHNICIAN
91	OTHER MEDICAL PROVIDER SPECIALTY (SPECIFY)